STATEMEN	IT OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE:). 0938-03
WE LAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN		COMPLETED	
		09G219	B. WING _		02/	2012000
NAME OF	PROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CC		28/2009
	HOMES, INC		6	15 55TH STREET, NE /ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
W 000	INITIAL COMMEN	TS	W 000			:
	Department of Discon March 19, 2009 Legal Services (UL attached report data findings of an on-sit March 8, 2009 and monitoring visit on result of the on-site alleging that identificate were at risk due to implement client material to the visits also note inadequate; limited offered and inadequater of the allegal	tion Licensing Administration referral via facsimile from the abilities Administration (DDA) a, submitted by the University S) monitoring team. The ed March 13, 2009 reflected te visit conducted on Sunday, a previously conducted September 28, 2008. As the visits, ULS filed a report led "Evans Class" members staff members on how to ealtime/positioning protocols. It is that staffing ratios were individualized activities were use community outings. The tions was defined as:		GOVERNMENT OF THE DISTRIC DEPARTMENT OF HE HEALTH REGULATION ADM 825 NORTH CAPITOL ST., N.E WASHINGTON, D.C.	ALTH INISTRATION L. 200 H. JUD	
	(b) Staff does not in adequately. One cla	ratios are not adequate; nplement feeding protocols are member displayed a			ļ	
	significant cough the (c) Staff have limited members' significan	d knowledge of the class	!			
1	(d) Staff are not ade protocols;	quately implementing position				
:	(e) Staff are not ade intake;	quately monitoring fluid	!			
: 1	(f) Staff does not add to protocol;	minister medication according	ļ		 	
	activities;	er meaningful, individualized	· · ·		:	
< W)	statement ending with an	RISUPPLIER REPRESENTATIVE'S SIGNAT		VP Operation	· · ()	x6) DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: S36P11

Facility ID: 09G219

If continuation sheet Page 1 of 16

CENT	RS FOR MEDICARE	& MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPL LDING	E CONSTRUCTION	(X3) DATE	SURVEY
		09G219	B. WIN	IG		03/	28/2009
	PROVIDER OR SUPPLIER HOMES, INC		•		ET ADDRESS, CITY, STATE, ZIP CODE 5 55TH STREET, NE		20/2009
	<u> </u>			WA	ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 000	Continued From pa	ge 1	W	000			
	(h): The clients are community outings;	not being provided adequate and					· !
	(i) Trash was obser parked on the lawn.	ved in the yard and a car was					
	survey was initiated March 28, 2009 utilized A random sample of	on March 26, 2009 through zing the full survey process.		:			
	degrees of disabilities The findings were be group home and two	ased on observations at the day programs, interviews					: : : : : : : : : : : : : : : : : : : :
	administrative staff, administrative record As a result of the fine	ome direct care staff, and and review of client and ds; including incident reports. dings, it was determined that					
	of Participation and I standard level deficie	mpliance with the Conditions ocal standards, however encies were cited. The nine concerns identified by					:
	: !	ately monitoring fluid intake;		:			
W 159	Staff were not admir according to protocol 483.430(a) QUALIFII RETARDATION PRO	ED MENTAL	W 15	59			
	Each client's active tr	reatment program must be ed and monitored by a				! !	
:		not met as evidenced by:				!	

PRINTED: 04/24/2009

		AND HUMAN SERVICES					D: 04/24/2009 M APPROVEI
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) I	MULTIF	PLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER:		ILDING			LETED
		09G219	B. WI	NG		03/	28/2009
NAME OF	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
METRO	HOMES, INC				5 55TH STREET, NE ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF	IX :	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE
W 150	Continued From		 -	- :	DEFICIENCY)		:
** 100	Continued From page		W	159			
	Qualified Mental Re	and record review, the tardation Professional		į			
	[QMRP] failed to en	sure the coordination of		!	W 150		į
	services for four of s	six clients residing in the			W 159 1. The individual's wheelch		•
	facility. [Clients #1, #	#2, #3 and #5]					
	The findings include	<u>.</u> .		!	tilt mechanism has not been		
	· · · · · · · · · · · · · · · · · · ·	5.			yet. The parts have been ord		1
	1. The QMRP failed	to ensure that #2's adaptive			by Essential Rehab and hav	e not	-
	: equipment was mair	ntained in good repair. [See		i	been delivered yet.		
	W436]	- , .			However the staff continues		
	2. The OMBD falls of			1	reposition him outside of hi	S	
	food in the texture re	to ensure Client #5 received ecommended in his mealtime			wheelchair - see attached		İ
	protocol. [See W192	, W331]		:	positioning record and lette. Essential Rehab.	r from	1 1 :
	3. The QMRP failed	to ensure Client #2's day		1	2. All staff were re trained i	n the	
	program was made a	aware of modifications in the			correct consistency for the l		:
	use of an adaptive c	up.		÷	 honey thick consistency. 	_	1
	O				future the QMRP and RN w		
	Observation during t	he lunch mealtime on March		1	ensure that all staff are com		
	Client #2 was conver	nately 12:00 PM revealed that		1	with the recommended mea	-	
	divided plate utilizing	his prescribed diet in a , with hand over hand		į			
	assistance, a built-ur	left angle coated spoon.			protocol, by monitoring the		
:	Further observation	revealed that Client #2 drank		!	during mealtimes at least w	•	'
	his beverage from ar	open handled dysphasia			and documenting meal intal		
	cup. According to the	e day program staff, the			3. The QMRP and the RN h		
:	adaptive equipment	was supplied by the group		1	corrected the POS to includ		
	nome. vvnen questio	ned about the use of a spout		!	order for a 'handled spouted	d cup'	
	chservation earlier th	the breakfast mealtime at day, the day program staff			for liquids. Acup has been s	sent to	İ
	reported that they we	re instructed to utilize the			the day program along with	a	[!]
:	dysphasia cup.			i	POS.		! !
	Upon return to the gr	oup home at approximately		!			
:	2:45 PM the QMRP w	vas interviewed. She		!			
!	mulcated that they ha	d been instructed in the past		:		•	
	TO MUNICULAR CARRING	CLUL HUWEVEL CUITANIN					

PRINTED: 04/24/2009

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES				PRINTE	D: 04/24/2009
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					M APPROVED 0. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) I A. BU		LTIPLE CONSTRUCTION DING	(X3) DATE COMPI	SURVEY
		09G219	B. WI	NG	i		001000
NAME OF F	PROVIDER OR SUPPLIER			Ţ	TREET ADDRESS OF A STATE OF A STA		28/2009
METRO	HOMES, INC			1	TREET ADDRESS, CITY, STATE, ZIP COL 615 55TH STREET, NE WASHINGTON, DC 20019	DE	
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 159	Continued From pa	ge 3	W	1 E	0		
	had been instructed of the speech thera 27, 2008 on March 27, 2008 on March 27, 2008 on March 27, 2008 on March 27, 2008 on March 28, 2008 on March 29, 2008 on March 2019, 22, 2008 on March 2019, 2019, 2019 on March 2019, 2019 on March 2019, 2019 on March 2019, 2019 on March 2019, 2019 on March 2019, 2019 on March 2019, 20	to use the spout cup. Review pist assessment dated July 26, 2009 at 4:00 PM indicated d to moderate dysphagia and use of the dysphasia cup, he July 29, 2008 nutrition 2 July 29, 2008 occupational at 4:15 PM revealed both use of a spout cup. Review of ealtime protocol indicates to ". Although both cups utilized it was unclear as to which cup(spouted or unspouted) ensure safe and adequate	**		4. This individual has a wheelchair and does not any use of pillows to ass his positioning. In the future the QMRP will ensure that all staff compliant with the recormealtime protocol, by m the staff during mealtime least weekly and docume meal intake.	require sist with and RN are mmended conitoring es at	4/30/09
	being prepared for lu on both sides of his blue neck support with breakfast observation were observed to poside of his chair, with place. He was positionentire meal in his whany meal time cough On March 27, 2009 afacility's physical their Client #3's wheelcha pillows. According to during the interim, unarrives, staff are to be one pillow place on o and the use of the blue mealtimes. He furthe support would allow resulting to a position of the place of the blue mealtimes.	wheelchair, and replaced his wheelchair, and replaced his wheelchair, and replaced his ith a pillow. During the n earlier that day, the staff sition one pillow on the left n the blue neck support in oned upright throughout the eelchair and did not exhibit ning. at approximately 3:30 PM the rapist was interviewed about ir status and the use of the the Physical therapist, ntil his new wheelchair e consistent with the use of the side of his wheelchair ue neck support during r indicated that the blue neck more flexibility than a pillow					
	to safety flex his necl	k back for oral intake. RP indicated that she would				:	

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES MEDICAID SERVICES			PRINTED FORM): 04/24/2009 1 APPROVED
STATEMEN	T OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CONSTRUCTION LDING	(X3) DATE S	. 0938-0391 SURVEY
		09G219	B. WIN	G	03/2	19/2000
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 55TH STREET, NE WASHINGTON, DC 20019		28/2009
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT	JLD BE	(X5) COMPLETION DATE
W 192	For employees who must focus on skills toward clients' healt This STANDARD is Based on observation review, the facility farained Medication direct care staff on the consistency for one modifications to the (Client #5) The findings include 1. (Cross refer to Watan approximately 8:50 A administered his memedications were crossuce. He received a spout cup after he medication/applesaut client's feeding proto approximately 3:30 Fewas to receive honey interview with the fact 2009, during the everal ministration, acknowledges according to the received and the second contraction of the received and the second contraction of the received and the second contraction of the received and the second contraction of the received and the second contraction of the received and the second contraction of the received the second contraction of the received the second contraction of t	m to ensure consistency. F TRAINING PROGRAM work with clients, training and competencies directed in needs. In not met as evidenced by: on, interview and record illed to effectively train the Employee (TME) and the he prescribed liquid of one client, that required consistency of his liquids. 331) On March 26, 2009 at AM, Client #5 was being dication. The client's ushed and placed in apple a thin consistency juice from consumed the ce mixture. Review of the col on the same day at AM, revealed that the client of consistency liquids. Illity's nurse on March 26, ning medication owledged that the client's cation administration should consistency, further	W 1	59 W192	s for y he are tary ed y N ded ing	4/30/09
	The facility's TME, h	owever failed to provide d to the client during the			!	

DEPAI CENTI	RTMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				FOR	D: 04/24/2009 M APPROVED
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPLE	CONSTRUCTION	(X3) DATE COMP	
		09G219	B. WII	VG		03/	28/2009
NAME OF	PROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	20/2009
METRO	HOMES, INC			615 5	55TH STREET, NE SHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTE (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPROPRICE (EACH OF THE APPROPRICE OF	JLD BE	(X5) COMPLETION DATE
W 192	Continued From page	ge 5	w ·	192			
	medication administ		**	· 02 ·			
W 242	#5 with his breakfasthe surveyor that Clithickener. The staff three tablespoons of with water. She show assisted the client, beconsumed his bever however, remained three tablespoons of the discussion and participated in the trained all staff on the 21, 2009, but indicate sheet. An evening staff of the discussion and participated in the trained all staff person the discussion and participated in the trained all staff on the 21, 2009, but indicate sheet. An evening staff of the discussion and participated in the trained all staff person meal was questioned used at mealtimes. Holds ten ounces of liscoops should have the honey consistency. The effectively train all staff appropriate beverage	cility nurse on March 26, aly 4:30 PM verified that the be thick, like honey, and that rate. The nurse presented the urveyor and pointed out loops per 4 ounces of liquid. Ilicated that she had recently ecorrect texture on March ed that there was no sign in aff was present at that time I stated that she had lining. When questioned thickner to use, she stated troximately 4:50 PM, the on preparing the evening I about the size of the cup le stated that the spout cup quids and that at least 8 ocen used to obtain the The facility failed to off on how to provide the consistency for Client #5.	W 24				
W 242	483.440(c)(6)(iii) IND	VIDUAL PROGRAM PLAN	W 24	2			

		AND HUMAN SERVICES					D: 04/24/2009 M APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		09G219	B. WI			03/	28/2009
	PROVIDER OR SUPPLIER			l	TREET ADDRESS, CITY, STATE, ZIP CODE 615 55TH STREET, NE WASHINGTON, DC 20019		20/2003
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	1X	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	those clients who la skills essential for p (including, but not lii personal hygiene, co bathing, dressing, g of basic needs), unt that the client is devacquiring them. This STANDARD is Based on staff intervacility failed to ensure the sample received the extent of their cathe house Manager made different natural his chair and encour buttons with his hand was observed placing times during this observed placing area and recent wash his hands. Review of his Mealtin December 23, 2008) should "Help [Client and nails thoroughly according to the review of the re	ram plan must include, for ck them, training in personal rivacy and independence mited to, toilet training, dental hygiene, self-feeding, rooming, and communication if it has been demonstrated elopmentally incapable of anot met as evidenced by: view and record review, the ire that one of three clients in training in hand washing to apability. (Client #1) at approximately 5:20 PM, activity room of the facility. (HM) placed a device that e sounds on the lap tray of aged the client to push the disto change the sounds. He g his fingers in his mouth at a servation. At approximately ras transported to the dining Prior to the client reaching the iving his snack, the staff did	W	242	<u> </u>	fection itiated see d RN ceive to lude e	4/30/09

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 04/24/2009 I APPROVED : 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIP	LE CONSTRUCTION	(X3) DATE S	URVEY
		09G219	B. WII	۷G		03/2	8/2009
	PROVIDER OR SUPPLIER HOMES, INC			61:	EET ADDRESS, CITY, STATE, ZIP CODE 5 55TH STREET, NE ASHINGTON, DC 20019	03/2	.0/2009
(X4) ID PREFIX TAG	(EACH DEFICIENCY)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 242	Continued From pa	ge 7	W 2	242			1
W 247	IPP failed to identify clients needs. The training program in	n activities of daily living. The programs to address the se was no evidence of a this area. DIVIDUAL PROGRAM PLAN	W 2				
	The individual programmer opportunities for clies self-management.	am plan must include ent choice and			W247 All staff were in serviced or	n	4/30/09
	Based on observation failed to ensure the opportunity to choos	s not met as evidenced by: on and interview, the facility clients were afforded an se their snacks for six of six the facility. (Client's #1, #2,			client's rights and choices. In the future the QMRP and will ensure that all staff are compliant with the recommmealtime protocol, by monithe staff during mealtimes a least weekly and documentimeal intake and client's cho	ended toring at ing	
W 261	On March 26, 2009, the clients received the clients were sentime during the observanther snack. The Professional (QMRF the Licensed Practic informed of the observith the QMRP at 6: lack of choices offered.	ensure each staff provided int choice as detailed below: at approximately 5:45 PM, their afternoon snack. All of yed chocolate pudding. At no envation were the clients ween the pudding and Qualified Mental Retardation P), House Manager (HM) and al Nurse (LPN) were envation. Further interview 00 PM acknowledged the ed to the clients. RAM MONITORING &	W 2	61			
	The facility must des constituted committee	ignate and use a specially e or committees consisting		; ; į			

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	D: 04/24/2009 M APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CONSTRUCTION	(X3) DATE	
		09G219	B. WIN	G	03/	28/2009
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 615 55TH STREET, NE WASHINGTON, DC 20019		20/2009
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORI	SHOULD BE	(X5) COMPLETION DATE
	guardians, clients (a persons who have e contemporary pract client behavior, and controlling interest in the STANDARD is Based on staff interfacility failed to design constituted committee (HRC) the ownership or controlling includes the finding includes. The finding includes Interview with the Quarter one of three clients. The finding includes the entrance conference tings had been behavior support plause of restrictive producember 3, 2008, wisits, the use of the harness and the need for a CT scan were received of the HRC saforementioned date approximately 1:45 Find that persons with no interest were included interview with the Holland Review of the larepresentative preservant.	ty staff, parents, legal as appropriate), qualified bether experience or training in idea to change inappropriate persons with no ownership or in the facility. In not met as evidenced by: view, and record review, the gnate and use a specially see, the Human Rights that included persons with no ling interest in the facility for in the sample. (Client #1) Lualified Mental Retardation on March 26, 2009 during ence revealed that HRC conducted to discuss ins, unusual incidents and the cedures for Client #1. On Client #1's Emergency room Geriatric Chair with a safety of for sedation (Ativan 2mg) reviewed and approved. Signature sheet for the end March 28, 2009 at PM revealed no evidence ownership or controlling d in the HRC approval. Fuse Manager (HM) on March mately 2:00 PM, ck of a community int during the meeting.	W 2		able to eported in hour or d neeting for her coupled ncy for mittee	4/30/09
	483.460(a)(3) PHYS		W 32	22 į		!

		I AND HUMAN SERVICES & MEDICAID SERVICES				FORM): 04/24/2009 1 APPROVED): 0938-0391
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE S	SURVEY
		09G219	B. WI	NG_		03/2	28/2009
METRO	PROVIDER OR SUPPLIER HOMES, INC				REET ADDRESS, CITY, STATE, ZIP CODE 615 55TH STREET, NE WASHINGTON, DC 20019	1 00/1	.0/2009
(X4) ID PREFIX TAG	 (EACH DEFICIENCY 	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 322	Continued From page	ge 9	W:	322			
:	This STANDARD is Based on observation review, the facility far preventative care see in the sample (Client client not in the same The findings include 1. During the medical March 26, 2009, standarch 26, 200	anot met as evidenced by: on, interview and record ailed to ensure general and ervices, for two of three clients its #2 and #3), to include one ple (client #5) ation pass observation on rting at approximately 8:15 be clients with the exception I lactulose. Interview and ed that the medication was n. Review of client #2, #3 Protocols reflected that the to encourage fluid intake. Berved receiving fluids bey, both in the home and at Review of the Fluid Intake 8, 2009 at approximately that the staff were not inting the fluid intake. Islaint made by the University), dated March 13, 2009; a e facility on March 8, 2009.		•	1. refer to W159 #2 2. The RN and LPN hat corrected the physicity order and the individed on an 1800 cal diabethigh fiber pureed diether future the RN with ensure that all consumer recommendations and medical records are reviewed monthly due the QA process so as deter a recurrence of 3. The QMRP has retrain all the staff on the individual's mealtime protocol. In the future the QMRP at RN will ensure that all staff at compliant with the recomment mealtime protocol, by monito the staff during mealtimes at least weekly and documenting meal intake.	ian's lual is lual is lictic, ll ltant ld the uring s to 'this. ned are nded oring	4/30/09

		I AND HUMAN SERVICES & MEDICAID SERVICES				FORM	D: 04/24/2009 M APPROVED D: 0938-0391
STATEMENT OF AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	MULTIP	PLE CONSTRUCTION	(X3) DATE COMPI	SURVEY
· · · · · · · · · · · · · · · · · · ·		09G219	B. WI	NG		03/	28/2009
NAME OF PROV	IDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
METRO HON	IES, INC			1	5 55TH STREET, NE ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 322 Co	ntinued From pa	ge 10	W	322			
reson refi with observed address revolution were were were were were add a served address recon were were were were his in of his that 1/2 even his in that 1/2 even his in that 1/2 even his in the served address revolution were were were even his in that 1/2 even his in that 1/2 even his in the served address revolution were even his in that 1/2 even his in the served address revolution were even his in the served address revolution were even his in the served address revolution were even his in the served address revolution and the served addr	ponse to the Ma March 27, 2009 ected the facility in the staff on Ma servations by the dilities training was ministrative staff servations and fire Review of Client Review of C	y's training records, in rch 13, 2009 ULS complaint, at approximately 10:30 AM, conducted in service training rch 23, 2009. Based on ULS and survey team, the sineffective. The was made aware of the adings on March 28, 2009. #2's July 22, 2008, nutrition ch 27, 2009 at 9:40 AM endation to change the client's 0 Kcals Diabetic, High Fiber, holesterol, no concentrated ed diet. Review of the ed January 9, 2009 reflected a shange diet to 1800 diabetic ex months later. Interview facility nurse at 9:50 AM order had not been changed e was no evidence that the ethe diet change had been ne of the survey. Fast mealtime observation 126, 2009 at 7:20 AM, staffing Client #3 his breakfast oughout the meal and after tes, to help clear food from appletion of his meal, a review 9, Feeding protocol revealed re a supplement; Prune juice (Breakfast and Dinner). At reakfast meal was he offered					
the :	orune juice.	medical record and March					

		AND HUMAN SERVICES MEDICAID SERVICES			FORM	D: 04/24/2009 M APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII	ULTIPLE CONSTRUCTION	(X3) DATE :	
		09G219	B. WIN	G	03/	28/2009
	PROVIDER OR SUPPLIER HOMES, INC		•	STREET ADDRESS, CITY, STATE, ZIP CODE 615 55TH STREET, NE WASHINGTON, DC 20019		20/2009
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRI	HOULD BE	(X5) COMPLETION DATE
W 322 W 331	PM, revealed that had 10ml (100 mg) twice daily for constipation	ers on March 26, 2009, at 2:30 e was prescribed colace liquid e daily and Lactulose 30 ml n.	W 3			
	This STANDARD is Based on observation review, the facility faliquid texture was propass for one of one liquid texture. (Client The finding includes On March 26, 2009, the Trained Medicate observed administer The client's medication apple sauce. He juice from a spout comedication/applesauclient feeding protoc approximately 3:30 for receive honey consists the facility's nurse or acknowledged that the thoney consistency.	at approximately 8:50 AM, ion Employee (TME) was ring medication to Client #5. ions were crushed and placed received a thin consistency up after he consumed the uce mixture. Review of the ol on the same day at PM, revealed the client was to stency liquids. Interview with		W331 All staff were re trained in correct consistency for the – honey thick consistency future the QMRP and RN ensure that all staff are conwith the recommended me protocol, by monitoring the during mealtimes at least vand documenting meal into	e liquid . In the will mpliant ealtime he staff weekly	4/30/09
W 369	483.460(k)(2) DRUG	administration must assure	W 36	9!	İ	

self-administered, are administered without error.

		I AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 04/24/2009 APPROVED : 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N		TIPLE CONSTRUCTION	(X3) DATE S COMPLI	URVEY
		09G219	B. Wii	NG		03/2	8/2009
	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 615 55TH STREET, NE WASHINGTON, DC 20019	00/2	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	-IX	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 369	Continued From pa	ge 12	w:	369			
	Based on observation verification, the facili medications were a	s not met as evidenced by: on, interview, and record lity failed to ensure dministered as prescribed for onts in the sample. (Client #1)			W369 All TMEs were re in-service the Policy and Procedures for the Policy and	or	4/30/09
	Trained Medication observed to adminis Among the medicaticc's. The Physician 2009) was reviewed observation, on Mar 11:00 AM. The orde was prescribed "ev" Review of the Me Record (MAR) on the days the medication were indicated by a respective date. The medication to be adrigued administered of 483.470(g)(2) SPAC The facility must furrand teach clients to choices about the ushearing and other coand other devices ideinterdisciplinary team	at approximately 8:15 AM, the Employee (TME) was ster Client #1 his medication. ons given was Lactulose 30 's Order's (dated March 1, to verify the medication pass ch 27, 2009 at approximately er reflected that the lactulose ery four days for constipation dication Administration e same day revealed that the were to be administered box drawn around the edate blocked off for the ministered was March 27, nedication was observed on March 26, 2008. E AND EQUIPMENT Thish, maintain in good repair, use and to make informed se of dentures, eyeglasses, emmunications aids, braces, entified by the client.	W 4	136	medication administration a documentation, mealtime protocols and safety proced for medication administration the future the RN will ensure the system of monthly monitoring of the TME during med pass is completed and appropriate correction and teaching is done at the time avert any recurrence.	ures on. In re that ing	
į	This STANDARD is	not met as evidenced by:		!		į	

CENTE		& MEDICAID SERVICES					APPROVED 0. 0938-0391
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		AULTIF ILDING	PLE CONSTRUCTION	(X3) DATE S	SURVEY
		09G219	B. WI	NG		03/2	28/2009
NAME OF	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
METRO	HOMES, INC			61	15 55TH STREET, NE (ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 436	Continued From pa	ge 13	W	436 i			:
	Based on observation	on, interview and record			W436		:
	review, the facility fa	ailed to ensure that each		:	The individual's wheelcha	ir – tilt	
	client's adaptive equ	ipment was maintained in		:	mechanism has not been fi	ixed	4/30/09
	good repair and clie	nts were taught to use and to ces about the use of the			yet. The parts have been o		
	devices one of the t	hree clients in the sample.		!	by Essential Rehab and hav		•
	(Client #2)	mee oneme in the sample.		;	been delivered yet.		:
	. T he feathers in the second	:		ļ	However the staff continue	s to	
	The finding includes	:		:	reposition him outside of h	is	1
	Interview with the O	ualified Mental Retardation		į	wheelchair - see attached		
	Professional (QMRF	P) on March 26, 2009 at 4:50		İ	positioning record and lette	er from	‡
	PM revealed that cli	ent #2's was to be		į	Essential Rehab. The QMR		!
	repositioned daily by	staff, every two hours in his		į.	continue to ensure that the		:
	wheelchair by utilizing	ig a tilt mechanism. At			reposition and document		
	demonstrate the use	PM the QMRP was asked to e of the tilting mechanism. It			repositioning as per the sys	tem in	
	was observed that the	ne wheelchair was missing		:	place – see attached position		
	the left handle on the	e back of the seat, rendering		!	record	·······	
	the chair's tilting cap	ability inoperable. The					i l
:	QMRP was not able	to tilt the chair.					
ĺ	Review of the client's	s record on March 27, 2009					
į	at 9:40 AM verified to	hat he was to be repositioned		i			İ
		er interview with the facility's		:			
:	physical therapist that	at same day at 4:15 PM		İ			İ
	revealed that repairs	to his wheelchair had been		ļ			
:	completed earlier in	the day (replaced foot box),		i		,	1
:	He indicated that alth	nanism remained on order, nough the client was capable				į	
	to reposition himself	while in the wheelchair, the		i		;	ł
i	tilting mechanism alle	owed more adequate				İ	
	repositioning options to maintain his skin integrity			i	·		ļ
W 455 j	483.470(I)(1) INFECT	TION CONTROL	W 4	55		į	
İ	There must be an ac	tive program for the		i			1
	prevention, control, a and communicable d	ind investigation of infection		!		i	

PRINTED: 04/24/2009

		AND HUMAN SERVICES MEDICAID SERVICES				FORM	0: 04/24/2009 MAPPROVED 0: 0938-0391
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) I A. BU		IPLE CONSTRUCTION	(X3) DATE :	SURVEY
		09G219	B. WI	NG_		03/	28/2009
	PROVIDER OR SUPPLIER HOMES, INC			6	REET ADDRESS, CITY, STATE, ZIP CODE 615 55TH STREET, NE WASHINGTON, DC 20019		20/2009
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
W 455	Continued From pa	ge 14	W	455			
	Based on observation review, the facility facontrol techniques a	s not met as evidenced by: on, interview and record ailed to implement infection as outlined in the feeding hree clients in the sample			W455 Refer to W242		:
	The finding includes): 		!			
W 474	Client #1 was in the The House Manage made different natural his chair and encound buttons with his hand was observed placing times during this observed placing times during this observed placing area for his snack. It dining area and recent wash his hands. Protocol (dated Decent that the staff should washed his hands areach meal." The homogeneous means are meal. The homogeneous means are meal. The homogeneous means are meal. The homogeneous means are means are means are means at the staff should washed his hands are each meal. The homogeneous means are means at the staff should washed his hands are each means. The homogeneous means are means at the staff should washed his hands are each means. The homogeneous means are means at the staff should washed his hands are each means at the staff should washed his hands are each means.	AL SERVICES	W 4	74	W474		
:	Food must be served developmental level	d in a form consistent with the of the client.			W474 Refer to W331	į	
	Based on observatio review, the facility fai (#5) clients residing i	not met as evidenced by: n, interview and record led to ensure that one of six n the facility received food in h his developmental level.					

		AND HUMAN SERVICES				FORM	0: 04/24/2009 APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G219		(X1) PROVIDER/SUPPLIER/CLIA	- 1	IULTIPL	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		09G219	B. WII	NG		021	29/2000
NAME OF P	PROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	28/2009
METRO	HOMES, INC			615	55TH STREET, NE SSHINGTON, DC 20019		:
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPROPRICE (DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 474	Continued From pa (Client #5)	ge 15	W	174			:
;	The finding includes	ļ ::		:			
: !	to ensure Client #5	2 and W331. The facility failed received his beverages in the ped. (Honey textured)				•	!
; 							
! !		 					
:		i		:			:
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!				!			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIES IDENTIFICATION NUM 09G219		ER/CLIA MBER:	(X2) MULTII A. BUILDING B. WING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED 03/28/2009	
NAME OF PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	03/28/2009	
METRO HOMES, INC		615 55TH WASHING	STREET, NE TON, DC 20	E 0019		
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE COMPLETE THE APPROPRIATE DATE	
1000 INITIAL COMMENT	rs	į	1 000			
(HRLA) received a repeatment of Disason March 19, 2009 Legal Services (ULS attached report date findings of an on-site March 8, 2009 and a monitoring visit on Services alleging that identifies were at risk due to simplement client me The visits also noted inadequate; limited i		from the (DDA) niversity The fflected Sunday, ed As the cort mbers w to otocols. were es were gs. The				
(b) Staff does not im adequately. One clas significant cough thro	plement feeding prot ss member displayed	ocols				
(c) Staff have limited members' significant	I knowledge of the cla t health risks;	ass				
(d) Staff are not adec position protocols;	quately implementing					
(e) Staff are not adec intake;	quately monitoring flu	id				
(f) Staff does not adn according to protocol	ninister medication	;			:	
(g) Staff does not offer activities;	er meaningful, individ	lualized				
alth Regulation Administration	ant Sk	Sank	NBSN 1	MA TITLES	(X6) DATE	
ORATORY DIRECTOR'S OR PROVIDER		ATIVE'S SIGNA	TURE S36	P11 VP Ofer	at ms 4/30/0	

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 09G219 03/28/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 615 55TH STREET, NE METRO HOMES, INC WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION 1D PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 1000 Continued From page 1 1000 (h): The clients are not being provided adequate community outings; and (i) Trash was observed in the yard and a car was parked on the lawn. A combination investigation/ recertification survey was initiated on March 26, 2009 through March 28, 2009 utilizing the full survey process. A random sample of three clients was selected from a population of six males with various degrees of disabilities. The findings were based on observations at the group home and two day programs, interviews with clients, group home direct care staff, and administrative staff, and review of client and administrative records; including incident reports. As a result of the findings, it was determined that the facility was in compliance with the Conditions of Participation and local standards, however standard level deficiencies were cited. The following two of the nine concerns identified by ULS were substantiated as follows: 4/30/09 I 223 All staff were in serviced again in Staff were not adequately monitoring fluid intake; repositioning, fluid intake, and medication administration, bedside Staff were not administering medication swallowing, leisure/recreation and according to protocol. active treatment. In the future, the QMRP, RN and 1223 3510.4 STAFF TRAINING 1223 Residential Coordinator will ensure that all staff will receive the Each training program agenda and record of staff participation shall be maintained in the GHMRP necessary in-service training to and available for review by regulatory agencies. equip them to care for the individuals. This Statute is not met as evidenced by: See attached – in-service training Based on review of staff training records and records personnel records, the GHMRP failed to make available agendas with documented staff

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 09G219 03/28/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 615 55TH STREET, NE METRO HOMES, INC WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 1223 Continued From page 2 1223 in-service training on seven of seven training's reviewed. The finding includes: Review of the staff in-service training book on March 28, 2009, at approximately 2:30 PM revealed that not all training activities contained the agenda outlining the content. (Accurate documentation, Repositioning, fluid intake, medication administration, Bedside swallowing, leisure/recreation and Active Treatment) 1291 3514.2 RESIDENT RECORDS 1291 Each record shall be kept current, dated, and 4/30/09 I291 signed by each individual who makes an entry. In the future the nursing staff will ensure that all documents reviewed This Statute is not met as evidenced by: Based on observation and record review the by the PCP will be initialed and GHMRP failed to ensure its primary care dated, to show the reviews were physician (PCP) dated entries made in the completed in a timely manner. medical record for three of three residents in the sample. (Resident #1, #2, and #3) The finding includes: Review of Resident #1 's medical record on March 26, 2009 and March 27, 2009 revealed the client received laboratory services and evaluations from several consultants. Although the PCP initialed the documents indicating the she had reviewed the documents, it could not be determined if the documents were reviewed timely because the PCP did not date the entries. Further reviews conducted on Resident #2 and #3's medical records on the same days evidenced the same findings.

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PRINTED: 04/24/2009 Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 09G219 03/28/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 615 55TH STREET, NE **METRO HOMES, INC** WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 1423 Continued From page 3 I423 1423 1. The individual's wheelchair -1423 3521.4 HABILITATION AND TRAINING 1423 tilt mechanism has not been fixed Each GHMRP shall monitor and review each yet. The parts have been ordered resident 's Individual Habilitation Plan on an by Essential Rehab and have not ongoing basis to ensure participation of the been delivered yet. resident and appropriate GHMRP staff in revision of such Plans whenever necessary. The schedule However the staff continues to for the reviews shall be documented within each reposition him outside of his IHP. wheelchair - see attached positioning record and letter from Essential Rehab. The OMRP will This Statute is not met as evidenced by: Based on interview and record review, the continue to ensure that the staff Qualified Mental Retardation Professional reposition and document (QMRP) failed to ensure the coordination of repositioning as per the system in services for three of three residents in the sample place - see attached positioning (Residents #1, #2 and #3) and one resident not in the sample. (Resident #5) 2. All staff were in-serviced by The findings include: the RN on the individual's mealtime protocol and the 1. The QMRP failed to ensure that the resident procedure to use Thick it to #2's adaptive equipment was maintained in good repair. [See Federal Deficiency Report-Citation obtain the ordered consistency. W4361 In the future the OMRP and RN will ensure that all staff are 2 The QMRP failed to ensure resident #5 compliant with the recommended received food in the texture recommended in his mealtime protocol, by monitoring mealtime protocol. [See Federal Deficiency Report-Citation W192 and W3221 the staff during mealtimes at least weekly and documenting 3. The QMRP failed to coordinate services with meal intake. Resident #2's day program to ensure the use of adaptive equipment during mealtimes as

evidenced by:

Observation during the lunch mealtime on March 26, 2009 at approximately 12:00 PM revealed that Resident #2 was served his prescribed diet in a divided plate utilizing, with hand over hand

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 09G219 03/28/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 615 55TH STREET, NE **METRO HOMES, INC** WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 1423 Continued From page 4 1423 assistance, a built-up left angle coated spoon. 3. The QMRP and the RN have Further observation revealed that Resident #2 corrected the POS to include the drank his beverage from an open handled order for a 'handled spouted cup' dysphasia cup. According to the day program 4/30/09 for liquids. A cup has been sent staff, the adaptive equipment was supplied by the group home. When questioned about the use of a to the day program along with a spout cup observed during the breakfast POS. mealtime observation earlier that day, the day 4. This individual has a new program staff reported that they were instructed wheelchair and does not require to utilize the dysphasia cup. any use of pillows to assist with Upon return to the group home at approximately his positioning. 2:45 PM the QMRP was interviewed. She indicated that they had been instructed in the past to utilize the dysphasia cup, however, currently was changed to a spout cup. Review of the speech therapist assessment dated July 27, 2008 indicated that Resident #2 presents mild to moderate dysphagia and recommended the use of the dysphasia cup, however review of the July 22, 2008 Nutrition assessment and July 29, 2008 Occupational Therapy assessment, both recommended the use of a spout cup. Review of the mealtime protocol indicates to use a "handled mug". Although both cups utilized were handled mugs, it was unclear as to which adaptive equipment cup(spouted or unspouted) was to be utilize to ensure safe and adequate dietary intake. On March 26, 2009 at 12:35 PM, Resident #3 was being prepared for lunch at the day program. The staff placed pillows on both sides of his wheelchair, and replaced the blue neck support with a pillow. However during the breakfast observation earlier that day, the staff were observed to position one pillow on the left side of his chair, with the blue neck support in place. He was positioned upright throughout the entire meal in his wheelchair and did not exhibit any meal time coughing.

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Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G219 03/28/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 615 55TH STREET, NE METRO HOMES, INC WASHINGTON, DC 20019 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 1423 Continued From page 5 1423 On March 27, 2009 at approximately 3:30 PM the facility's physical therapist was interviewed about Resident #3's wheelchair status and the use of the pillows. According to the Physical therapist, during the interim, until his new wheelchair arrives, staff are to be consistent with the use of one pillow place on one side of his wheelchair and the use of the blue neck support during mealtimes. He further indicated that the blue neck support would allow more flexibility than a pillow to safety flex his neck back for oral intake. Interview with the QMRP indicated that she would visit the day program to ensure consistency. 1 432 3521.7(c) HABILITATION AND TRAINING 1432 The habilitation and training of residents by the GHMRP shall include, when appropriate, but not **I432** be limited to, the following areas: The OMRP and the RN have 4/30/09 retrained all the staff on infection (c) Personal hygiene (including washing, bathing, control. The OMRP has initiated shampooing, brushing teeth, and menstrual a hand washing program - see care); attached This Statute is not met as evidenced by: In the future the QMRP and RN Based on staff interview and record review, the will ensure that all staff receive facility failed to ensure that one of three residents training which is necessary to in the sample received training in hand washing provide safety and will include to the extent of their capability. (Resident #1) programs appropriate to the The finding includes: individual's needs. See attached training – infection On March 26, 2009 at approximately 5:20 PM, control and IPP for hand washing Resident #1 was in the activity room of the facility. The House Manager (HM) placed a device that made different nature sounds on the lap tray of his chair and encouraged the client to push the buttons with his hand to change the sounds. He was observed placing his fingers in

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Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B WING 09G219 03/28/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 615 55TH STREET, NE **METRO HOMES, INC** WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 1432 Continued From page 6 1432 his mouth at times during this observation. At approximately 5:35 PM, Resident #1 was transported to the dining area for his snack. Prior to the client reaching the dining area and receiving his snack, the staff did not wash his hands. Review of his Mealtime Protocol (dated December 23, 2008) reflected that the staff should "Help [Resident name] to washed his hands and nails thoroughly prior to each meal." According to the review of the Individual Support Plan dated February 2008, the resident requires staff assistance with activities of daily living. The IPP failed to identified programs to address the residents needs. There was no evidence of a training program in this area.